ARC 4429C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to a passive managed care enrollment process

The Human Services Department hereby amends Chapter 73, "Managed Care," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

These amendments revise language to reflect the Department's implementation of a passive managed care enrollment process. For Medicaid eligibility groups subject to mandatory managed care enrollment, members will be passively enrolled with a managed care plan no earlier than the first day of the month of the member's application to Medicaid, with no initial fee-for-service (FFS) period. Additionally, outdated language is being removed in order to appropriately reflect the responsibility that managed care organizations (MCOs) have for retroactive eligibility periods.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on February 13, 2019, as **ARC 4289C**. The Department received no comments during the public comment period. No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on April 10, 2019.

Fiscal Impact

This rule making has a fiscal impact to the State of Iowa of less than $100,000 annually or $500,000 over five years. The Medicaid actuary has communicated that no material fiscal impact is anticipated. The cost would be shifted from FFS claims payments to MCO cap payments. Theoretically, in the aggregate, there should not be a substantial difference in the cost. However, home- and community-based services (HCBS) members would not have received any HCBS services for those first one to two months (or longer). With passive managed care enrollment, the MCO will immediately receive the HCBS cap rate, so in those instances the MCO may perhaps receive a higher payment than would have otherwise been paid out in FFS. There will be a capitation payment sooner for HCBS members, but member expenditures are typically less while awaiting MCO assignment, which will be reflected in capitation rate development (increasing member months with a small decrease in expenditures evens out any difference).

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on July 1, 2019.

The following rule-making actions are adopted:

ITEM 1. Adopt the following **new** definition of "Passive enrollment process" in rule **441—73.1(249A)**:

"Passive enrollment process" means the process by which the department assigns a member to a managed care organization and which, in accordance with 42 CFR 438.54, seeks to preserve existing provider-member relationships and relationships with providers that have traditionally served Medicaid members, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available managed care organizations.

ITEM 2. Amend rule 441—73.3(249A) as follows:

441—73.3(249A) Enrollment.

73.3(1) and **73.3(2)** No change.

73.3(3) *Enrollment process.* The department shall notify members who must be enrolled in a managed care organization of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to ~~October 16, 2015~~ May 6, 2016.

a. No change.

b. ~~*Tentative*~~ *Passive assignment.* ~~Members~~ Effective no earlier than the first day of the month of the member's application to Medicaid, the member shall be ~~tentatively~~ assigned to a managed care organization using the department's passive enrollment process and offered the opportunity to choose from the available managed care organizations within a time frame specified in the ~~tentative~~ passive assignment letter.

c. *Request to change enrollment.* An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Enrollment changes are effective no later than the first day of the second month beginning after the date on which the enrollment broker receives the enrollee's written or verbal request.

~~(1) A member shall have a minimum of ten days from the date of the tentative assignment letter to request enrollment with a different managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).~~

~~(2) An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made~~

~~on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).~~

d. and *e.* No change.

~~**73.3(4)** *Effective date of enrollment.* The effective date of enrollment shall be no later than the first day of the second month beginning after the date on which the managed care organization receives the designated managed health care choice form or written or verbal request.~~

~~**73.3(5)**~~ **73.3(4)** *Benefit reimbursement prior to enrollment.*

a. Prior to the effective date of managed care enrollment, except as provided in paragraph ~~73.3(5)*"b,"*~~ 73.3(4)*"b,"* the Medicaid program shall reimburse providers for covered program benefits pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

b. The managed care organization shall be responsible for covering newly retroactive Medicaid eligibility periods~~,~~ prior to the effective date of enrollment~~, in the following cases:~~

~~(1)~~ ~~Babies~~ for babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth~~; and~~.

~~(2) Children enrolled in the HAWK-I program retroactive to the date of application. For purposes of this requirement, a retroactive Medicaid eligibility period is defined as a period of time up to three months prior to the Medicaid determination month.~~

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 5/8/19.